U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 December 2005

***In the Matter of*:**

OTIS E. NELSON,
Claimant,

v.

CASE NO: 2004 BLA 6119

JEWELL RIDGE MINING COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

***Appearances*:**

Otis E. Nelson, *pro se*
For the Claimant

H. Ashby Dickerson, Esq.
For the Employer

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

Statement of the Case

This proceeding involves a claim for benefits filed under the Black Lung Benefits Act, as amended, 30 U.S.C. § 901 *et seq*. ("Act"), and the regulations promulgated thereunder.[1] Since Claimant filed this application for benefits after March 31, 1980, Part 718 applies. This claim is

[1] All applicable regulations which are cited in this Decision and Order are included in Title 20, Code of Federal Regulations, and are cited by part or section only. The Director's exhibits are denoted "D-"; Claimant's exhibits, "C-"; Employer's exhibits, "E-"; and citations to the transcript of the hearing, "Tr."

governed by the law of the United States Court of Appeals for the Fourth Circuit, since Claimant was last employed in the coal industry in the State of Virginia. *See Kopp v. Director*, *OWCP*, 877 F.2d 307, 12 B.L.R. 2-299 (4th Cir. 1989); *Shupe v. Director*, *OWCP*, 12 B.L.R. 1-200 (1989) (*en banc*).

Otis E. Nelson (the "Claimant") filed his first claim for benefits under the Act on April 1, 1975. (D-1). This claim was awarded by Initial Determination dated August 25, 1976. (D-1). After a request for a hearing before the Office of Administrative Law Judges and a remand to the District Director, a Decision and Order Awarding Benefits was rendered by Administrative Law Judge Pacht. (D-1). The award was subsequently appealed to the Benefits Review Board which affirmed in part, vacated in part and remanded the claim to the Office of Administrative Law Judges in an unpublished opinion, dated January 20, 1987. (D-1). On remand, Judge Bonfanti denied the claim finding that Claimant had failed to establish a total disability due to a work related impairment. (D-1). A judgment was later entered regarding the overpayment of benefits to Claimant. (D-1). That debt was determined to be permanently uncollectable by the United States Department of Justice on April 9, 1996 and the claim was closed. (D-1).

Claimant filed a second, subsequent, claim for benefits on March 10, 2003. (D-3). A Schedule for the Submission of Additional Evidence was issued on August 27, 2003 finding that if a determination were made at that time, Claimant would be entitled to benefits. (D-20). A Proposed Decision and Order was issued on December 11, 2003 finding that Claimant failed to establish any element of entitlement. (D-30). Claimant requested a hearing before the Office of Administrative Law Judges on December 22, 2003. (D-32).

On April 5, 2003, the claim was referred to the Office of Administrative Law Judges for a formal hearing. (D-35). This hearing was conducted before the undersigned in Abingdon, Virginia on September 22, 2004. Director's Exhibits 1-37 (D-1-37) and Employer's Exhibit 1-6 (E-1-6) were admitted into evidence. (Tr. 17, 44).

Issues

1. Whether Claimant has proved the existence of pneumoconiosis.
2. If so, whether Claimant's pneumoconiosis arose out of his coal mine employment.
3. Whether Claimant suffers from total respiratory disability.
4. Whether such total respiratory disability is due to pneumoconiosis.
5. Whether Claimant has established an element of entitlement previously adjudicated against him.
6. The length of Claimant's coal mine employment.

Counsel for the employer withdrew as issues the timeliness of the claim, whether Claimant was a miner engaged in coal mine employment after 1969, and whether Employer is the properly designated responsible operator. (Tr. 15).

Findings of Fact

Background and Dependents

Claimant, Otis E. Nelson, was born on March 10, 1935, and was 69 years old at the time of the formal hearing. (Tr. 12). He has never been married. (Tr. 12). The only sources of income for Claimant are Social Security Disability and his miner's pension. (Tr. 12-13). He testified at length regarding his coal mine employment. He was last employed by Pittston Coal Company. (Tr. 13). He last worked on April 20, 1976. (Tr. 14). He claims a total of 20 years of coal mine employment. (Tr. 14). He began working in coal mine employment in 1954 for Jewell Branch Coal Company as a hand loader. (Tr. 18). He worked in that position for 4 years. (Tr. 18). He then went to work for W.H. Hicks and Teen Coal Company for 6 or 7 years as a motorman and hand loader. (Tr. 19). In 1958 and 1959, he worked for P&W Coal Company and T.A. Perkins Coal Company. (Tr. 20). He stated that he would work for these companies on an inconsistent basis when he was not working for W.H. Hicks. (Tr. 20).

Claimant then worked for Jeff Coal Company, beginning in 1960 for 1 ½ to 2 years. (Tr. 21). Claimant does not remember working for Jenes Coal Company in 1961, although it is listed on his coal mine employment worksheet. (Tr. 21). During 1962, Claimant worked for Willis Lowe and Alfred Jewells, Perkins Coal Company and Howard Lowe Coal Company. (Tr. 21). For a period of 2 years, beginning in 1962, he worked as a hand loader for Willis Lowe and Alfred Jewells. (Tr. 21). From 1964 to 1966, he worked hand loading coal for Ray Coal Company. (Tr. 24). He then worked for Richardson Coal Company from 1966 to 1969. (Tr. 24). Beginning in 1970, he went to work for Jewell Ridge Coal Company. (Tr. 25). He worked for Jewell Ridge on several different occasions as a motorman, tent top and miner operator. (Tr. 25). Claimant testified that he worked for Jewell Ridge from March 1970 to March 1973, was sick and laid off from March 1973 to May 1973 and returned to work in May 1973 until November 1973. (Tr. 26-27). From November 1973 to April 1974, Claimant did not work because the mine was shut down. (Tr. 27). He returned to work from April 1974 to April 1976 in a different mine. (Tr. 28).

Claimant last worked in 1976, leaving his employment because of his health. (Tr. 29). Claimant stated that he first noticed breathing difficulties 2 to 3 years before leaving the mine and that the condition has gotten steadily worse. (Tr. 30). Since the time of his previous denial, Claimant states that his breathing has gotten worse and that he must sleep on two pillows. (Tr. 31-35). Claimant testified that he has never smoked. (Tr. 37). When asked whether he has ever suffered from tuberculosis, Claimant stated that he had not. (Tr. 37). On cross-examination, Claimant was faced with a report by a Dr. Buffington from 1976 indicating a positive result on a tuberculosis test. (Tr. 38). In response, Claimant stated that he had seen that information in a report. (Tr. 38).

Medical Reports and Opinions

The following medical reports were developed subsequent to the denial of Claimant's previous claim.

Dr. J. Randolph Forehand[2]

Dr. Forehand examined Claimant on April 25, 2003, pursuant to the obligation of DOL to provide Claimant with a complete pulmonary evaluation. (D-11). Dr. Forehand conducted a physical examination, recorded a patient history, and administered clinical testing. (D-11). He recorded that Claimant's last job was as a shuttle car operator, pin top and miner helper, with a total coal mine employment history of 20 years. He further noted that Claimant has never smoked. Current medical complaints included sputum production, wheezing, dyspnea on exertion, a productive cough, and exertional chest pain. On physical examination, Dr. Forehand noted normal chest configuration with diminished breath sounds and crackles.

Dr. Forehand found the existence of complicated pneumoconiosis on the basis of a chest x-ray interpretation, physical examination, Claimant's history and the arterial blood gas testing. Dr. Forehand attributes this condition to coal dust exposure. Dr. Forehand found the existence of a significant respiratory impairment rendering Claimant unable to return to his previous coal mine employment. Dr. Forehand went on to state that Claimant is totally and permanently disabled and that coal workers' pneumoconiosis is the sole factor contributing to Claimant's respiratory impairment.

Dr. Kirk Hippensteel

Dr. Hippensteel examined Claimant on October 14, 2003, offering a report dated November 6, 2003. (D-29). Dr. Hippensteel is board-certified in internal medicine and pulmonary disease and is a NIOSH-certified B-reader. Dr. Hippensteel noted a 68 year old man with 20 years of underground coal mine employment. Dr. Hippensteel noted Claimant's last coal mine employment to be as a pinner, shuttle car operator and continuous miner operator. He further listed the requirements of these positions. Claimant reported to Dr. Hippensteel that he began suffering from breathing difficulties before leaving the mine. He further reported symptoms including a daily cough, 2 colds in the last year, previous pneumonias and chest pain. Claimant stated that he had no history of asthma or exposure to tuberculosis (hereinafter "TB"). Claimant also reported that he never smoked. On physical examination, Claimant's AP diameter was mildly increased with no rales or wheezing. Dr. Hippensteel reviewed Dr. Wheeler's interpretation of Claimant's chest x-ray and CT scan, both of which were negative for the existence of pneumoconiosis. The diagnostic testing completed showed a moderate airflow obstruction and normal resting gas exchange. Dr. Hippensteel concluded that Claimant suffers from a pulmonary impairment from obstructive lung disease as a result of a congenital chest wall deformity, generalized emphysematous blebs and two conglomerate lesions unrelated to coal workers' pneumoconiosis. Dr. Hippensteel concluded that Claimant would be in the same condition if he had never been employed as a miner.

[2] This tribunal takes judicial notice of Dr. Forehand's professional qualifications as board-certified in allergy and immunology and in pediatrics, and is a B-reader. Board-certifications are listed by the American Board of Medical Specialties at www.abms.org. B-reader qualifications are recorded on the *List of Approved B-Readers* published on the website of the Department of Labor's Office of Administrative Law Judges at www.oalj.dol.gov/public/blalung/refrnc/bread3.htm. *See Maddaleni v. Pittsburg & Midway Coal Co*., 14 BLR 1-135 (1990).

Dr. Hippensteel authored an addendum to his November 6, 2003 report dated December 5, 2003. (D-29). At that time, Dr. Hippensteel had the opportunity to review the medical evidence from Claimant's prior claim for benefits. Dr. Hippensteel noted that Claimant's history was significant for treatment for TB resulting from a positive skin test. This lead Dr. Hippensteel to conclude that Claimant's chest x-rays and CT scan were consistent with healed tuberculosis lesions rather than coal workers' pneumoconiosis. He noted deterioration in Claimant's function which he attributes to Claimant's congenital chest wall deformity. Dr. Hippensteel opined that Claimant's chest x-ray and CT scan do not show small opacities to go along with the large opacities and that the absence of those small opacities leads him to believe that Claimant's testing does not indicate coal workers' pneumoconiosis. Dr. Hippensteel further noted that the small opacities on Claimant's chest x-rays from the 1970s have resolved which does not happen with coal workers' pneumoconiosis. Dr. Hippensteel stated that his conclusions remained the same.

Dr. Hippensteel was also deposed in connection with this claim on September 16, 2004. (E-5). Dr. Hippensteel again reviewed the occupational history and symptoms noted at his original examination. (E-5, pp. 8-10). Claimant reported to Dr. Hippensteel that he had no history of exposure to tuberculosis. (E-5, p. 11). Claimant's medical records contradict this statement in that his mother suffered from TB in 1959 and Claimant had a positive skin test in July 1975. (E-5, p. 11). Claimant was treated with isoniazid. (E-5, p. 11). Claimant's chest x-ray at the time was positive for TB, but his sputum test was negative. (E-5, p. 12). Dr. Hippensteel explained that this can happen when a person spontaneously heals from TB. (E-5, p. 12). The TB becomes inactive and treatment with isoniazid lessens the chances of reactivation of the disease. (E-5, p 12).

Dr. Hippensteel also discussed Claimant's chest wall deformity. Dr. Hippensteel opined that this condition contributes to Claimant's respiratory condition because when some of the ribs are not connected in the proper way, the muscles contained therein cannot contribute to the exertion of the lungs to get a "good breath." (E-5, p. 13). An EKG performed at Claimant's examination shows evidence of cardiac problems or disease. (E-5, p.14). Dr. Hippensteel discussed Dr. Wheeler's interpretation of Claimant's chest x-ray and CT scan. (E-5, pp. 16-18). He agrees with Dr. Wheeler that complicated pneumoconiosis is not present. (E-5, p. 17). The testing does not show any coal dust related pulmonary process and is consistent with healed TB. (E-5, p. 17). Dr. Hippensteel discounts the masses on the chest x-rays and CT scans as pneumoconiosis because of the lack of background nodules. (E-5, p. 18). He would expect to see small opacities as well as larger masses if complicated pneumoconiosis were present. (E-5, p. 18). Dr. Hippensteel takes issue with Dr. Forehand's finding of complicated pneumoconiosis. In Dr. Forehand's chest x-ray interpretation, he makes a 1/0 finding, but finds complicated pneumoconiosis. (E-5, p. 19). Dr. Hippensteel believes that this is problematic because Dr. Forehand made a marginal finding of pneumoconiosis and that a 1/0 finding is insufficient to classify the larger masses as complicated pneumoconiosis. (E-5, p. 19).

In discussing Claimant's CT scan, Dr. Hippensteel again stated that the test is consistent with healed TB with emphysematous blebs throughout the lungs. (E-5, p. 24). Dr. Hippensteel believes that the CT scan shows healed TB based on Claimant's positive skin test. (E-5, p. 25). Dr. Hippensteel does not agree with Dr. Antoun that the masses on the CT scan are consistent

with pneumoconiosis. (E-5, p. 26). Dr. Hippensteel believes that the report is deficient in that no differential diagnosis of granulomatous disease is made and there is no mention of small surrounding opacities. (E-5, p. 27).

Dr. Hippensteel also discussed the emphysematous blebs seen with Claimant. Dr. Hippensteel opines that these can be associated with complicated pneumoconiosis, but that the location of these blebs are not associated with the conglomerate lesions. (E-5, p. 29). This leads Dr. Hippensteel to conclude that the emphysematous blebs are a congenital problem unrelated to coal workers' pneumoconiosis. (E-5, p. 29). Dr. Hippensteel discussed the pulmonary function study conducted at the time of his examination which showed a moderate air flow obstruction. (E-5, p. 33). Claimant's lung volumes showed hyperinflation with no restriction and a mildly reduced diffusing capacity. (E-5, p. 33). He opined that Claimant's condition is unrelated to coal dust exposure. (E-5, p. 33).

In conclusion, Dr. Hippensteel stated that Claimant does not suffer from coal workers' pneumoconiosis and the masses seen on chest x-ray and CT scan are not coal workers' pneumoconiosis. (E-5, p. 35). The process seen on those tests is typical for granulomatous disease and does not suggest coal workers' pneumoconiosis or progressive massive fibrosis. (E-5, p. 35). Claimant does not suffer from any lung disease related to or aggravated by coal dust exposure. (E-5, p. 36). Claimant does suffer from a respiratory impairment that would prevent him from returning to his previous coal mine employment; however, that impairment is not related to coal dust exposure and is a result of conglomerate granulomatous disease that resulted from Claimant's exposure to TB, as well as congenital problems with bullous emphysema. (E-5, pp. 36-37). Dr. Hippensteel concluded that Claimant's pulmonary disability is unrelated to his coal dust exposure and that he would be in the same condition had he never worked in the coal mining industry. (E-5, p. 38).

Dr. James R. Castle

Dr. Castle examined Claimant on August 25, 2004. (E-2). Dr. Castle is board-certified in internal medicine and pulmonary disease and is a NIOSH-certified B-reader. Claimant reported his symptoms to include shortness of breath, productive cough, wheezing and brief chest pain. He reported no history of asthma or TB. He is a non-smoker with 20 years of coal mine employment ending in 1976. He last worked as a pinner. Dr. Castle noted the job description in his report. On physical examination, Claimant's chest showed a congenital deformity of the sternum. Breath sounds were equal with no rales, rhonci, wheezes, rubs, crackles or crepitations. Dr. Castle reviewed the chest x-ray interpretation by Dr. Wheeler that was negative for pneumoconiosis. The pulmonary function study conducted at the time of the examination was invalid due to less than maximal effort and variability. Dr. Castle concluded that Claimant does not suffer from pneumoconiosis, but does suffer from a congenital chest wall deformity and old granulomatous disease with calcified pulmonary nodules. Dr. Castle further found evidence of bullous emphysema, possible coronary artery disease and degenerative arthritis.

Dr. Castle reviewed Claimant's medical records from both this claim and the previous claim for benefits. Dr. Castle found three risk factors in Claimant's history: coal dust exposure,

TB and cardiac disease. Dr. Castle noted that Claimant had a family history of TB with exposure from this mother. He had several positive PPD tests and was given prophylactic therapy. The chest x-ray and CT scan findings are "consistent with healed TB with bilateral apical and suprahilar calcified nodules with associated pleural changes due to TB." In addressing Claimant's cardiac disease, he noted that Claimant did not mention anything to him about having cardiac disease, but the EKG results were consistent with a previous heart attack. Dr. Castle stated that Claimant's chest wall deformity could also result in physiologic changes.

Dr. Castle found nothing consistent with any interstitial pulmonary process. Dr. Castle believes that the changes seen on the chest x-rays are due to old granulomatous disease and not coal workers' pneumoconiosis. The CT scan results were also typical of what would be seen with healed TB. Based on Dr. Hippensteel's pulmonary function testing, Dr. Castle opined that Claimant suffers from a moderate airway obstruction with hyperinflation, gas trapping and a mild diffusion impairment. These changes are due to bullous emphysema and old granulomatous disease as well as Claimant's chest wall deformity. Claimant's arterial blood gas testing indicates occasional findings of hypoxemia. Dr. Castle attributes this to bullous emphysema and not coal workers' pneumoconiosis. Dr. Castle disagrees with Dr. Forehand because Dr. Forehand did not consider granulomatous disease as part of a differential diagnosis or cause of Claimant's impairment. Dr. Castle believes that this is because Dr. Forehand was unaware of Claimant's history of positive TB skin tests and the CT scan results. Dr. Castle concluded that coal workers' pneumoconiosis is not present. He believes that Claimant is "probably permanently and totally disabled as a whole man because of old granulomatous disease, congenital chest wall deformity and congenital bullous emphysema." None of these conditions is related to coal dust exposure. Dr. Castle found no disability related to or aggravated by Claimant's exposure to coal dust.

Dr. Castle was deposed on September 20, 2004. (E-6). At that time, he reiterated the history and findings noted in the report of his examination on July 21, 2004. (E-6, pp. 5-9). Claimant indicated to Dr. Castle that he had no history of exposure to TB. (E-6, p. 7). Dr. Castle reviewed Claimant's medical records that indicate a positive TB test in the 1970s with exposure to his mother with TB 16 years before the positive test. (E-6, pp. 7-8). The fact that Claimant's skin test was positive without a positive sputum test indicates that the disease was not active at that time. (E-6, p. 8). Claimant was given the treatment customary for a person with a positive skin test and healed TB. (E-6, p. 9). Dr. Castle's physical examination revealed a congenital deformity of the sternum. (E-6, p. 10). This causes Claimant to not have the "normal mechanical properties in the chest." (E-6, p. 10). The problem would become more manifest as Claimant ages. (E-6, p. 10).

Dr. Castle relied on a chest x-ray interpretation by Dr. Wheeler that was negative for pneumoconiosis. (E-6, p. 12). The chest x-ray showed bullous emphysema as well as two masses. (E-6, p. 12). Dr. Castle agrees with Dr. Wheeler that the x-ray does not show pneumoconiosis, but is consistent with old granulomatous disease, i.e. TB. (E-6, p. 12-13). Dr. Castle also took issue with Dr. Forehand's interpretation of Claimant's chest x-ray. Dr. Castle explained that large opacities are not seen with a 1/0 film. (E-6, p. 14). This interpretation indicates that Dr. Forehand considered reading the x-ray as negative. (E-6, p. 14). Dr. Castle went on to explain that complicated pneumoconiosis develops because of large amounts of dust

exposure causing a large number of small opacities. (E-6, p. 14). The lesions typically seen are not like the ones on Claimant's chest x-rays. (E-6, p. 15). Dr. Castle also believes that Claimant's February 2003 CT scan supports a finding of healed TB. (E-6, p. 15).

Claimant's bullous emphysema causes large dilated air spaces within the lungs. (E-6, p. 19). Coal workers' pneumoconiosis can cause emphysema, but not the type seen with Claimant, according to Dr. Castle. (E-6, p. 19). Bullous emphysema is most typically seen with smoking or granulomatous disease. (E-6, p. 19-20). All of Claimant's arterial blood gas tests were normal, indicating to Dr. Castle that if complicated pneumoconiosis were present, some degree of hypoxemia would be seen. (E-6, pp. 21-22).

Dr. Castle's pulmonary function study did not produce valid results. (E-6, p. 22). The valid testing in the record indicates to Dr. Castle that Claimant suffers from a moderate degree of obstruction with hyperinflation and gas trapping. (E-6, p. 23). There is a mild decrease in the diffusion capacity consistent with bullous emphysema. (E-6, p. 23). These findings, according to Dr. Castle, show the changes that are associated with "significant granulomatous disease which resulted in the development of bullous emphysema." (E-6, p. 23). Dr. Castle concluded that Claimant does not suffer from coal workers' pneumoconiosis or any chronic disease of the lungs that is related to or aggravated by coal dust exposure. (E-6, p. 24). Claimant does have a respiratory impairment that would prevent him from returning to his previous coal mine employment, but that impairment is a result of bullous emphysema and old granulomatous disease with a congenital chest wall deformity. (E-6, pp. 24-25).

CT Scans

February 20, 2003

Dr. Basim Antoun interpreted Claimant's CT scan taken on February 20, 2003.[3] (D-15). Dr. Antoun noted a 5 centimeter heavily calcified mass in the right upper paraspinal and paratracheal. He also found a 2.5 centimeter stellate mass in the apex of the left upper lobe. Dr. Antoun found emphysematous changes throughout the remainder of the lungs. Dr. Antoun opined that the "findings may suggest benign underlying process such as confluence of masses sequela or coal workers' pneumoconiosis, etc."

Dr. Paul S. Wheeler also interpreted this CT scan. Dr. Wheeler is board-certified in radiology and is a certified B-reader. (D-28). Dr. Wheeler identified 2 masses, one 5 centimeters and the other 3 centimeters that were compatible with conglomerate TB. He also found moderate emphysema. He found no evidence of pneumoconiosis. He does not believe that the masses are large opacities of coal workers' pneumoconiosis because they are centrally calcified and there are no small background nodules.

October 14, 2003

[3] This tribunal takes judicial notice of Dr. Antoun's professional qualifications as board-certified in diagnostic radiology from the list of the American Board of Medical Specialties at www.abms.org. *See Maddaleni v. Pittsburg & Midway Coal Co*., 14 BLR 1-135 (1990).

Dr. Kirk Hippensteel performed a CT scan as part of his evaluation of Claimant. (D-28). The scan showed a 6 centimeter calcified conglomerate lesion and a partially calcified 4 centimeter lesion. No significant rounded opacities were found coalescing into the lesions and no finding of coal workers' pneumoconiosis was made. Dr. Hippensteel opined that the CT scan is consistent with conglomerate granulomatous disease, as well s emphysematous bleb and a sternal deformity.

X-Ray Evidence[4]

The following x-ray interpretations have been submitted for this subsequent claim:

Exh. No.	X-ray Date Reading Date	Physician	Qualifications	Film Quality	Interpretation
D-15	4-25-03 4-25-03	Forehand	B	1	1/0; A
D-15	4-25-03 5-20-03	Navani	B/BCR	1	Read for quality – noted bullae, cancer and emphysema
D-28	4-25-03 10-31-03	Wheeler	B/BCR	1	Negative
D-29	10-14-03 10-24-03	Hippensteel	B	2	Negative
E-2	7-21-04 7-21-04	Wheeler	B/BCR	2	Negative

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The quality standards for pulmonary function studies performed after January 19, 2001, are found at § 718.103 (2005).

[4] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "BCR". An interpretation of "0/0" signifies that the film was read completely negative for pneumoconiosis. A notation of "N/R" indicates that the result was not recorded on the report.

The following pulmonary function studies were developed for this subsequent claim[5]:

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify	Impression cooperation comprehension tracings
D-12[6] 4-25-03 Forehand	68 68"	1.70 1.73	3.05 2.94	56% 59%	31 42	Yes Yes	"good" coop/comp tracings attached – expiratory volumes are decreased – obstructive ventilatory pattern – evidence of exercise induced arterial hypoxemia
D-29 & E-1 10-14-03 Hippensteel	68 69"	1.59 1.68	3.11 3.13	51% 54%	39 N/R	Yes Yes	coop/comp not recorded - tracings attached – moderate airflow obstruction
E-2 7-21-04 Castle	69 69"	1.50 1.17	2.22 2.53	67% 46%	23 N/R	Yes Yes	coop/comp not recorded – not valid due to less than maximal effort and variability – lung volume shows hyperinflation and gas trapping

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The quality standards for arterial blood gas studies performed after January 19, 2001, are found at § 718.105 (2005). A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, an exercise blood gas test can be offered.

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[5] "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. § 718.204(b)(2)(i) (2005). Claimant's height has been measured at values between 68 and 69 inches. His height for purposes of evaluating the pulmonary function study results is determined to be 68.5 inches. *See Protopappas v. Director, OWCP*, 6 B.L.R. 1- 221 (1983). *See also Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116, 19 B.L.R. 2-70 (4th Cir. 1995).

[6] Dr. J. Michos, who is board certified in internal medicine and pulmonary disease, found this test to be of acceptable quality, but with a suboptimal MVV performance. (D-14).

Tests with only one figure represent studies at rest only.

The following arterial blood gas study evidence was developed for this subsequent claim:

Exhibit Number	Date Altitude	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify
D-13[7]	4-25-03 <2999'	Forehand	28 28	81 71	No Yes
D-29	10-14-03 <2999'	Hippensteel	34.4	80	No
E-2	7-21-04 <2999'	Castle	34.2	75.4	No

Conclusions of Law and Discussion

Complete Pulmonary Evaluation

The Director has fulfilled the Department's statutory obligation to provide the Claimant with a complete pulmonary evaluation pursuant to Section 413(b) of the Act. 30 U.S.C. §923(b), as implemented by §§ 718.102, 725.405 and 725.406. The Department of Labor would not have satisfied this obligation if the physician who performed the pulmonary evaluation at the request of the Department had not addressed a necessary element of entitlement. *See Cline v. Director*, *OWCP*, 972 F.2d 234, 14 B.L.R. 2-102 (8th Cir. 1992); *Collins v. Director*, *OWCP*, 932 F.2d 1191, 15 B.L.R. 2-108 (7th Cir. 1991); *Newman v. Director*, *OWCP*, 745 F.2d 1161, 1166 (8th Cir. 1984); *Hodges v. BethEnergy Mines Corp.*, 18 B.L.R. 1-84 (1994). This obligation applies to duplicate and subsequent claims. *Hall v. Director*, *OWCP*, 14 B.L.R. 1-51 (1990).

In his medical report and opinion Dr. Forehand affirmatively diagnosed pneumoconiosis based on the chest x-ray, exposure history, physical examination and arterial blood gas testing. (D-11). His reference to "Coal Dust Exposure" establishes a nexus with coal mine employment. (D-11). Dr. Forehand further found that Claimant suffers from a totally disabling respiratory impairment that resulted solely from his exposure to coal dust. Thus he addressed all elements of entitlement essential to a pulmonary evaluation under the Act.

Subsequent Claim

Because Claimant filed the instant claim on March 10, 2003, more than one year after the final denial of his previous claim, this constitutes a subsequent claim. The applicable regulations provide with respect to subsequent claims that:

[7] Dr. J. Michos found this testing to be of acceptable quality. (D-14).

The amended regulations dispense with the "material change in condition" language and contain a threshold standard, generally adopting the position of the Benefits Review Board and several circuit courts that the claimant must meet before his claim may be reviewed de novo:

> (d) A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E & F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see Secs. 725.202(a) (miner), 725.212 (spouse), 725.218 (child), and 725.222 (parent, brother or sister)) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
>
> (1) Any evidence submitted in connection with any prior claim shall be a made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
>
> (3) If the applicable condition(s) of entitlement related to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement.
>
> . . .
>
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see §725.463) shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in the adjudication with the prior claim shall

> be binding on that party in the adjudication of the subsequent claim.

§ 725.309(d)(2005). It is noted that, pursuant to § 725.409, if a prior claim has been denied by reason of abandonment, then it shall constitute "a finding that the claimant has not established any applicable condition of entitlement." § 725.409(c)(2005).

The newly developed medical evidence in this case does not establish that Claimant has pneumoconiosis or a totally disabling pulmonary or respiratory impairment due to pneumoconiosis. The medical evidence generated subsequent to the denial of Claimant's previous claim does persuasively establish that one of the applicable conditions of entitlement has changed since the time of the prior denial. Claimant has established that he suffers from a totally disabling respiratory impairment. However, because he has not established the existence of pneumoconiosis or that pneumoconiosis is a substantially contributing cause of his pulmonary disability, his claim must be denied.

Pneumoconiosis

For purposes of the Act, pneumoconiosis means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. A disease arising out of coal mine employment includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. 30 U.S.C. § 902(b); § 718.201. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he has pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis contributes to his total disability. § 718.202(d)(2)(2001). *Mullins Coal Co., Inc. of Virginia v. Director, OWCP*, 484 U.S. 135, 141, 11 B.L.R. 2-1 (1987). *Jericol Mining*, *Inc. v. Napier*, 301 F.3d 703, 708, 22 B.L.R. 2-537 (6th Cir. 2002). The failure to prove any requisite element precludes a finding of entitlement. *Anderson v. Valley Camp of Utah*, *Inc*., 12 B.L.R. 1-111 (1989); *Perry v. Director*, *OWCP*, 9 B.L.R. 1-1 (1986) (*en banc*).

Because this claim arises within the Fourth Circuit, the administrative law judge must weigh all of the evidence together to determine whether Claimant suffers from the disease. *Island Creek Coal Co. v. Compton,* 211 F.3d 203 (4th Cir. 2000). The existence of pneumoconiosis may be based upon x-ray evidence under § 718.202(a)(1); upon the basis of autopsy or biopsy evidence under § 718.202(a)(2); or by certain presumptions under § 718.202(a)(3), if applicable. In this case, § 718.305 does not apply to claims filed after January 1, 1982 and § 718.306 applies only to survivors' claims filed prior to June 30, 1982. A miner may also establish the existence of pneumoconiosis under § 718.202(a)(4) on the basis of a reasoned medical opinion based upon objective medical evidence which supports a diagnosis of pneumoconiosis.

X-Ray Evidence

The record pertinent to the instant claim contains five interpretations of three chest x-rays that were taken after the final denial of Claimant's previous claim. Dr. Forehand is the only

physician to read the chest x-ray as positive for the existence of pneumoconiosis. He also reads that film as showing complicated pneumoconiosis. (D-15). Drs. Wheeler and Hippensteel read Claimant's films as negative for pneumoconiosis. (D-28 & 29, E-2). The other reading makes no finding as to the presence or absence of pneumoconiosis. (D-15). The interpretation by Employer's experts prevail on the basis of their expertise and credentials. Greater weight is properly given to x-ray readings performed by B-readers over interpretations by physicians who possess no particular radiological qualifications. *See LaBelle Processing Company v. Swarrow*, 72 F.3d 308, 20 B.L.R. 2-76 (3rd Cir. 1995). Greater weight may be given to the readings of physicians who are both B-readers and Board-certified radiologists. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985). *See Zeigler Coal Co. v. Director*, *OWCP* [*Hawker*], 326 F.3d 894, 899, __ B.L.R. 2-___ (7th Cir. 2003). Dr. Forehand is a B-reader. However, Dr. Hippensteel is also a B-reader and Dr. Wheeler is board-certified in radiology as well as being a B-reader. Consequently, Claimant has not established the presence of pneumoconiosis on the basis of x-ray evidence at § 718.202(a)(1).

Medical Opinion Evidence

Since there is no evidence relevant to biopsy or autopsy, the existence of pneumoconiosis is not established under § 718.202 (a)(2). Therefore, the medical opinion evidence may determine whether Claimant has established the presence of pneumoconiosis under that provision.

The sole medical opinion diagnosis of pneumoconiosis that was submitted by Claimant is that of Dr. Forehand.[8] Dr. Forehand diagnosed pneumoconiosis. On this record Dr. Forehand's diagnosis of pneumoconiosis is unpersuasive. Dr. Forehand does not make any note of Claimant's history of TB which is relevant in making an accurate reading of Claimant's chest x-rays. It is also relevant in considering the source of Claimant's pulmonary condition. Because he has not considered this information, it is not possible to accord Dr. Forehand's opinion the weight that is given to Drs. Hippensteel's and Castle's opinions as they did consider Claimant's history of exposure to TB and his positive skin test. The opinions of Drs. Hippensteel and Castle are further supported by Dr. Wheeler's and Dr. Hippensteel's interpretations of Claimant's CT scans. (D-28). The CT scan findings support the doctors' conclusions. A physical examination and history may qualify in an appropriate case as a reasoned medical opinion. *See Poole v. Freeman United Coal Mining Co*., 897 F.2d 888, 893, 13 B.L.R. 2-348 (7th Cir. 1990). *Gomola v. Manor Mining and Contracting Corp.*, 2 B.L.R. 1-130 (1979). The probative value of medical opinions depends upon "the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses." *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441, 21 B.L.R. 2-269 (4th Cir. 1997). *See Underwood v. Elkay Mining, Inc*., 105 F.3d 946, 950-951, 21 B.L.R. 2-23 (4th Cir. 1997). Due to the fact that Dr. Forehand did not consider Claimant's history of TB or his chest wall abnormality in rendering his opinion, his opinion is entitled to less weight as it does not fully consider all of the significant medical documentation.

[8] Dr. Antoun's diagnosis of pneumoconiosis based on the February 20, 2003 CT scan is unpersuasive. (D-15). Based on Dr. Antoun's own wording of his findings, he does not appear convinced that pneumoconiosis is present. He states that the findings "may suggest a benign underlying process such as confluence of masses sequela of CWP, etc." This finding can be considered equivocal, at best. He does not definitively diagnose pneumoconiosis. Therefore, his opinion has been accorded appropriately diminished weight in this determination.

The opinions of Drs. Hippensteel and Castle are more persuasive and better based on the objective medical data contained in the record.

Dr. Forehand's medical opinion that Claimant has pneumoconiosis, including any pulmonary or respiratory impairment significantly related to, or substantially aggravated by, Claimant's coal mine dust exposure, is not persuasive. In contrast, Drs. Hippensteel and Castle persuasively account for the Claimant's history of TB exposure and treatment, his congenital chest wall deformity and his many years of coal mine dust exposure in ruling out that exposure in the development of any pulmonary condition. *Cf. Peabody Coal Co. v. Hill*, 123 F.3d 412, 417, 21 B.L.R. 2-192 (6th Cir. 1997). Therefore, the medical opinion diagnosis of pneumoconiosis does not establish the existence of that disease pursuant to § 718.202(a)(4).

Pursuant to the Fourth Circuit's holding in *Island Creek Coal Co. v. Compton, supra.*, all of the available means to establish pneumoconiosis must be weighed together to determine if Claimant suffers from the disease. Weighing all of the evidence of record together, I find that Claimant has failed to establish the existence of pneumoconiosis by a preponderance of the evidence.

Total Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), or if he is totally disabled due to pneumoconiosis, 30 U.S.C. § 902(f), §§ 718.204(a) (2005). Dr. Forehand diagnosed Claimant as suffering from complicated pneumoconiosis. As stated above, that opinion is unpersuasive. Therefore, Claimant is not entitled to the presumption at § 718.304.

The applicable regulations provide for proof of total disability, other than by the presence of complicated pneumoconiosis, by: (1) qualifying pulmonary function studies; (2) qualifying blood gas studies; (3) evidence of cor pulmonale with right-sided congestive heart failure; (4) reasoned medical opinions based upon appropriate diagnostic techniques; and (5) in certain circumstances, lay testimony. §§ 718.204(b)(2005). In a living miner's claim, lay testimony cannot support the finding of a totally disabling respiratory impairment in the absence of corroborating evidence. *See Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122 (1999). Claimant does not suffer from complicated pneumoconiosis; there is no evidence of cor pulmonale; and Claimant has not established total respiratory disability pursuant to §§ 718.204(b)(1) or (2) (2005).

All of Claimant's valid pulmonary function studies produced qualifying values. Therefore, he has established a total respiratory disability by a preponderance of the pulmonary function study evidence. Only one of Claimant's four arterial blood gas test results produced a qualifying value under the applicable regulations. Since the remaining three tests do not produce qualifying values, Claimant has not established total respiratory disability by a preponderance of the arterial blood gas test results.

The medical opinion evidence proves total respiratory disability pursuant to § 718.204(b)(4). All three doctors rendering opinions in this matter agree that Claimant is

disabled from returning to his previous coal mine employment. § 718.204(b)(1); (D-11 & 29, E-2 & 5). Based on these opinions, all of the physicians of record found the existence of a totally disabling respiratory impairment. Therefore, Claimant has established that he suffers from a totally disabling respiratory impairment. However, establishing a totally disabling respiratory impairment is only part of Claimant's burden. He must also establish that pneumoconiosis is a substantially contributing cause of that total disability. § 718.204(c).

A claimant must establish not only that he suffers from a totally disabling respiratory impairment, but also that the condition is a result of his pneumoconiosis. Section 718.204(c)(2005) provides:

> A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis … is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a 'substantially contributing cause' of the miner's disability if it: (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

Pursuant to § 718.204(b)(1), "all of the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element." *Mazgaju v. Valley Camp Coal Co.,* 9 B.L.R. 1-201, 1-204 (1986).

Dr. Forehand attributes Claimant's respiratory disability to coal workers' pneumoconiosis. (D-11). As previously discussed, this opinion is unpersuasive. Dr. Forehand does not consider Claimant's positive history for TB in making this determination, nor does he make any reference to Claimant's chest wall deformity. Therefore, his opinion as to the source of Claimant's pulmonary disability is unpersuasive. Drs. Hippensteel and Castle agree that Claimant's pulmonary disability is a result of his bullous emphysema, healed granulomatous disease and chest wall deformity. None of these conditions is the result of coal workers' pneumoconiosis or any disease process that resulted from Claimant's exposure to coal mine dust. (D-29, E-2 & 5). These opinions are persuasive as to the source of Claimant's totally disabling respiratory impairment. Notwithstanding the weight of all of the evidence regarding total disability due to pneumoconiosis together, Claimant has not established total disability due to pneumoconiosis.

All relevant evidence submitted with this subsequent claim establishes that Claimant now suffers from a totally disabling respiratory impairment, but does not establish that Claimant suffers from pneumoconiosis or a total respiratory disability due to pneumoconiosis. The foregoing analysis compels the determination that Claimant has not established that he suffers from pneumoconiosis or that pneumoconiosis is a substantially contributing cause to his totally disabling respiratory impairment. Therefore, Claimant has not established the necessary elements of entitlement to benefits under the Act.

Conclusion

Claimant has established an element of entitlement previously adjudicated against him. However, that element alone is insufficient to support an award for benefits. On the record as a whole, Claimant has not established the existence of pneumoconiosis or a total respiratory disability due to pneumoconiosis. In light of these conclusions, it is not necessary to decide the issue relating to the length of Claimant's coal mine employment.

ORDER

The claim of Otis E. Nelson for benefits under the Act is denied.[9]

A

Edward Terhune Miller
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

[9] The award of an attorney's fee under the Act is permitted only in cases in which the Claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes